306 276 - 277 HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE

306.1 GENERAL INFORMATION

Introduction

This chapter contains information on processing claim status requests and responses based on the ASC X12N Health Care Claim Status Request and Response (276 - 277) (004010X093) Implementation Guide and the Addenda (004010X093A1) dated October 2002. This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).

Questions, comments, or suggestions regarding this chapter should be directed by email to hfswebmaster@illinois.gov

When to Submit a 276 (Status Request)

The Claims Status Request and Response (276 - 277) Transaction set will be used to convey claims status information on claims received by the Department. The intent of this transaction is to answer questions such as:

- Did you receive my claim?
- Where is my claim in your system?
- What is the status of my claim (paid, rejected, in process, suspended, etc.)?

The information provided in the transaction will reflect the status of the claim at the time the request was made. The status of the claim may change. This transaction will NOT automatically notify a provider about a change in claim status. Status information will only be provided upon request.

The intent of the 277 transaction is NOT to provide information explaining how the claim was processed or why certain amounts were paid. Answers to these types of questions will be contained in the electronic HIPAA Remittance Advice (835) transaction.

The Department will provide status information on claims that are on file in the HFS system. It will attempt to identify a previously accepted claim using the information that is contained in the 276 request. Finding the right claim upon receipt of the initial 276 will eliminate the need for follow-up. The likelihood of identifying the correct claim will be increased if the conventions outlined in this document are followed in preparing the 276 request.

Grouping and Processing

The REV and MEDI systems offer a mechanism by which a single Claim Status Inquiry request can be processed and returned in a real-time mode. Under normal conditions, the response to any real-time inquiry will return in a matter of seconds. A single Claim Status Inquiry request, also referred to as a real-time request, is defined as a single transaction with only one claim level request or one service line level request. For real-time, if additional transactions and service lines are sent, HFS will process only the first request and ignore all others. Additionally, the MEDI IEC system will offer a mechanism whereby 276 X12 formatted transactions will be processed in a batch mode. For batch, multiple transactions and service lines are acceptable. Batch transactions will be accumulated throughout the day and under normal conditions, the response will occur within 24 hours.

EDI Information

For HFS, the Patient is always the Subscriber.

Business Scenarios

1. SITUATION: The 276 contains data that will not be validated against the Department's databases.

   ACTION: The 277 response will reflect the information that was submitted on the 276.

   EXAMPLE A: The **Subscriber's Name** is identified in the 276 as a John Doe. The Department's files show the **Subscriber Name** as Jonathon Doe. The Department will return a 277 response with the name John Doe.

   NOTE: The submitter should check the Department's Recipient Database via a 270 transaction to validate the enrolled name and other pertinent information for the participant.

   EXAMPLE B: The **Provider's Name** is identified in the 276 as Jane Smith. The Department's files show that based on the Provider Number submitted the **Provider's Name** is Janet Smith. The Department will return a 277 response with the name Jane Smith.

2. SITUATION: The Claim requested on the 276 has been voided.

ACTION: The 277 response will contain the claim that was requested with a Claim Status Category Code (507) code of F3 and a Claim Status Code (508) code of 1, which indicates that the particular claim/service requested was voided in the HFS claims system.

306.2 TECHNICAL INFORMATION

This section contains information relating to transmitting information to the Department. This section will identify, down to the data element level, anything unique to the Department in regards to the EDI transaction.

Transmission Information

The Department will continue to support its Recipient Eligibility Verification (REV) system. The REV system allows authorized Vendors a means to submit and receive electronic transactions, on behalf of Providers, for processing. The Department will also support a Medicaid Electronic Data Interchange (MEDI) system whereby authorized Providers and their agents can submit and receive electronic transactions via the Internet.

EDI Information:

The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the various EDI transactions. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide.

Information Request Considerations:

In submitting a 276 (Claims Status Request), the requester needs to understand the information that they receive will be based on the data elements submitted. While all submissions will require certain data elements, the inclusion of the Department's Document Control Number (DCN) in the Reference Identification field (REF02) of Loop 2200D, Payer Claim Identification Number segment, will cause the return of data associated only with that DCN. If the particular claim / service had an adjustment processed against it or a void / rebill was successfully completed, these additional transactions will not be displayed using the DCN as a part of the search key. If the requester desires to see all of the transactions associated with a particular claim / service, then do not enter the DCN. The system will respond with all transactions that meet the Provider – Recipient – Date of Service – Procedure Code / NDC criteria for Professional / Pharmacy claims or Provider – Recipient – Date of Service for Institutional claims.

Error Code Reporting

Users of the pre-HIPAA Illinois Medicaid Management Information Systems (MMIS) are familiar with both the claims submission and reporting formats. With the transition to the HIPAA formats there will be changes in both the claims submission and reporting formats.

HFS currently utilizes Form DPA 194-M-1, (Remittance Advice), to report the status of claims and adjustments processed. The Department will continue to produce the paper Remittance Advice after the implementation of HIPAA.

The HIPAA 835 (Electronic Remittance Advice) can be used to report a payment; send an Explanation of Benefits (EOB) remittance advice, or report a payment and send an EOB Remittance Advice from a health care payer to a health care provider. The Department has crosswalked our error codes, currently reported on the HFS Remittance Advice, to the HIPAA mandated reason and remarks codes.

The HIPAA 277 will be used by the Department to transmit the current status of the claims within the HFS adjudication process to the requester. The Department has crosswalked our status and error codes to the HIPAA mandated Health Care Claim Status Category Codes and Health Care Claim Status Codes. The HIPAA codes will be reported on the 277 transaction.

The Department will be reporting rejected claims on the 835 and the 276 – 277 transactions but not in the detail that the Department currently uses. The Department will continue to produce the IDPA Form 194-M-1 in paper media. The proprietary error codes and messages, which have been used by the Department in the past, will continue to be reported on the paper Remittance Advice. Explanations of these error codes may be found at the Department's website http://www.hfs.illinois.gov/handbooks/chapter100.html under Medical Programs; Provider Handbooks; Chapter 100; Appendix 5 (Error Code Explanations).

HFS Unique 276 Status Request Items

IG Page #	Loop ID	Segment Name	Reference Description	Element Name	Special Instructions
55	2100A	Payer Name	NM103	Name Last or Organization Name	Must be “ILLINOIS MEDICAID”.
55	2100A	Payer Name	NM108	Identification Code Qualifier	Strongly recommend the use of “FI”.
56	2100A	Payer Name	NM109	Identification Code	Must be “37-1320188” for HFS.
68	2100C	Provider Name	NM108	Identification Code Qualifier	Must be “SV”.
69	2100C	Provider Name	NM109	Identification Code	Must contain your 9, 10 or 12-digit HFS Provider Number.
71	2000D	Subscriber Level	HL04	Hierarchical Child Code	Strongly recommend the use of “0” (zero).
74	2100D	Subscriber Name	NM101	Entity Identifier Code	Strongly recommend the use of “QC”.
75	2100D	Subscriber Name	NM102	Entity Type Qualifier	Strongly recommend the use of “1”.
75	2100D	Subscriber Name	NM108	Identification Code Qualifier	Strongly recommend the use of “MI”.
76	2100D	Subscriber Name	NM109	Identification Code	Must be the Patient’s 9-digit ID number as shown on the IL MediPlan Card, KidCare Card or SeniorCare Card.
79	2200D	Payer Claim Identification Number	REF02	Reference Identification	If used, this field must contain, in the first 15 positions, the Document Control Number (DCN) assigned by HFS. HFS will accept a DCN, SS (Service Section), VOUCHER format, but will only process the first 15 positions of this field. If the DCN is provided, only information about this specific claim will be returned on the 277.

IG Page #	Loop ID	Segment Name	Reference Description	Element Name	Special Instructions
80	2200D	Institutional Bill Type Identification	REF02	Reference Identification	This value is strongly recommended if the inquiry is for an institutional claim.
82	2200D	Group Number	REF02	Reference Identification	Must contain “INST” if the status request is for an 837I, except Home Health claim, or a paper UB claim; Must contain “PROF” if the status request is for an 837P claim; an 837I Home Health claim or any Non-Institutional Providers (NIPS) paper claims; Must contain “PHAR” if the status request is for a Pharmacy claim, either electronic or paper; Must contain “DENT” if the status request is for a dental claim.
94	2000E	Dependent Level	All		Dependent loops are not used as the patient and subscriber are always the same for HFS.
115	2210E	Service Line Information	SVC01-2	Product / Service ID	Strongly recommend the use of HCPCS codes for NIPS billings and NDC codes for Pharmacy billings.

277 Claim Status Response

- The REF02 field in loop 2200D (Payer Claim Identification Number segment) will contain three data elements concatenated as follows: Document Control Number (fifteen digits) Service Section Number (two digits) Voucher Number (eleven digits). The Service Section Number will always be "00", since this loop is the claim level and Professional claims only have Service Section numbers at the service line level and Institutional claims do not have service line level. The format for this field will be CCYYJJJLLNNNNNNSSCCYYJJJNNNN.
  C = Century
  Y = Year J = Julian Date
  L = Line Number assigned by HFS
  N = Sequential Number assigned by HFS
  S = Service Section

- HFS has indicated which elements have not been validated but contain the value submitted in the 276 transaction.

- Loop 2100A (Payer Contact Information) is not used by the Department.

HFS Unique 277 Status Response Items

IG Page #	Loop ID	Segment Name	Reference Description	Element Name	Special Instructions
131	2100A	Payer Name	NM103	Name Last or Organization Name	Will be "ILLINOIS MEDICAID".
131	2100A	Payer Name	NM108	Identification Code Qualifier	"FI" will be returned.
132	2100A	Payer Name	NM109	Identification Code	"37-1320188" will be returned for HFS.
139	2100B	Information Receiver Name	NM108	Identification Code Qualifier	Field will contain the same value as submitted in the 276.
140	2100B	Information Receiver Name	NM109	Identification Code	Field will contain the same value as submitted in the 276.

IG Page #	Loop ID	Segment Name	Reference Description	Element Name	Special Instructions
144	2100C	Provider Name	NM108	Identification Code Qualifier	Field will contain the same value as submitted in the 276.
145	2100C	Provider Name	NM109	Identification Code	Field will contain the same value as submitted in the 276.
147	2000D	Subscriber Level	HL04	Hierarchical Child Code	Field will contain “0” (zero). Subscriber is always patient for HFS.
149	2000D	Subscriber Demographic I	DMG02	Date Time Period	Field will contain the same value as submitted in the 276.
149	2000D	Subscriber Demographic	DMG03	Gender Code	Field will contain the same value as submitted in the 276.
150	2100D	Subscriber Name	NM101	Entity Identifier Code	“QC” will be returned.
151	2100D	Subscriber Name	NM102	Entity Type Qualifier	“1” will always be returned.
151	2100D	Subscriber Name	NM104 to NM107	Name First, Name Middle, Name Prefix, Name Suffix	Field will contain the same value as submitted in the 276.
151	2100D	Subscriber Name	NM108	Identification Code Qualifier	“MI” will be returned.
152	2100D	Subscriber Name	NM109	Identification Code	Field will contain the same value as submitted in the 276.
153	2200D	Claim Submitter Trace Number	TRN02	Reference Identification	Field will contain the same value as submitted in the 276.
162	2200D	Claim Level Status Information	STC04	Monetary Amount	Field will contain the amount as submitted in the 276.
=163	2200D	Claim Level Status Information	STC07	Payment Method Code	Field will contain either "ACH" or "CHK" or "NON". NON will appear with a paid service when the net amount of the voucher is zero.

IG Page #	Loop ID	Segment Name	Reference Description	Element Name	Special Instructions
163	2200D	Claim Level Status Information	STC09	Check Number	If STC07 = “CHK”, will contain the Warrant number. If STC07 = “ACH”, will contain the EFT trace number.
166	2200D	Payer Claim Identification Number	REF02	Reference Identification	Document Control Number -Service Section-Voucher Number of claim assigned by HFS. See DCN definition above. HFS will return the DCN, if submitted in 276. If the DCN is not submitted, but is found on Department’s database, then that value will be returned. If DCN is not submitted and not found on database, a “blank” will be returned.
168	2200D	Institutional Bill Type Identification	REF02	Reference Identification	Field will contain the same value as submitted in the 276.
169	2200D	Medical Record Identification	REF02	Reference Identification	Field will contain the same value as submitted in the 276.
174	2220D	Service Line Information	SVC01-1	Procedure / Service ID Qualifier	Field will contain the same value as submitted in the 276.
175	2220D	Service Line Information	SVC02	Monetary Amount	Field will contain the same value as submitted in the 276.